

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/09/2012
NAME OF PROVIDER OR SUPPLIER HEARTH AT TUDOR GARDENS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11755 N MICHIGAN RD ZIONSVILLE, IN 46077		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00106034 completed on 04/13/12.</p> <p>Complaint IN00106034 - corrected.</p> <p>Survey date: May 9, 2012</p> <p>Facility number: 012263 Provider number: 012263 AIM number: N/A</p> <p>Survey team: Christi Davidson, RN-TC Lora Brettnacher, RN</p> <p>Census bed type: Residential: 109 Total: 109</p> <p>Census payor type: Other: 109 Total: 109</p> <p>Sample: 3</p> <p>The Hearth at Tudor Gardens was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00106034.</p> <p>Quality review 5/10/12 by Suzanne Williams, RN</p>	{R 000}		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

TR0X12

If continuation sheet 1 of 1